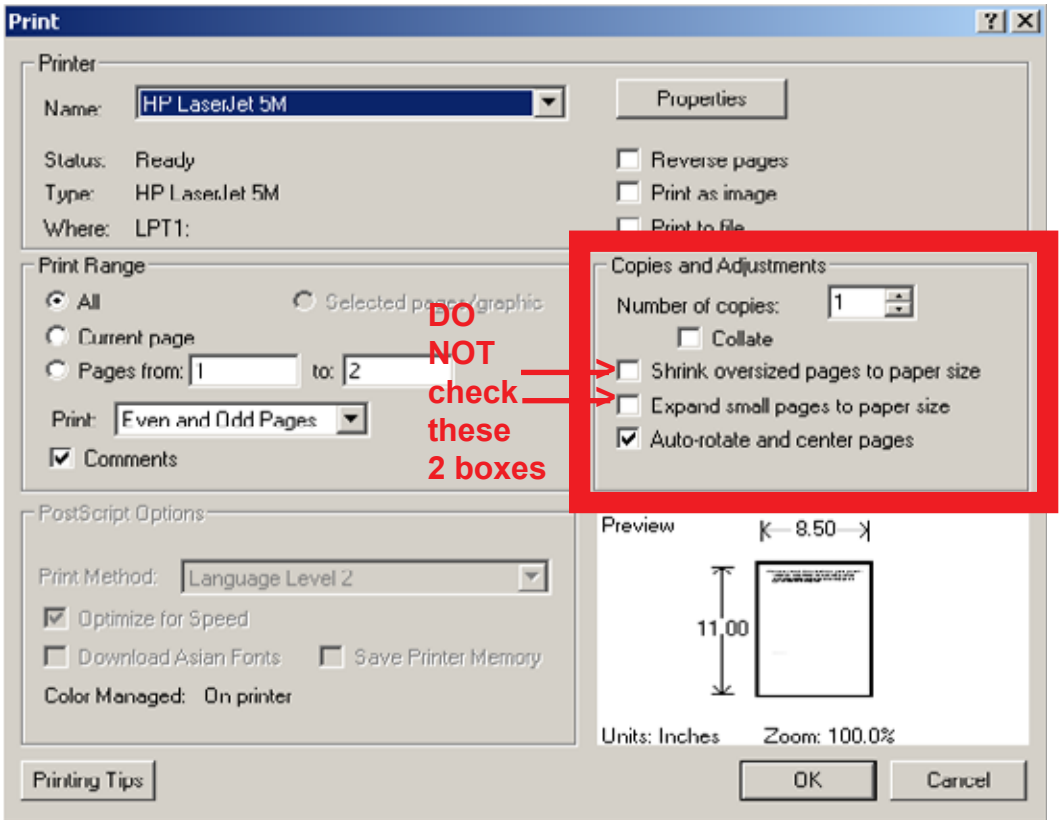
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box "Auto-rotate and center pages." Do **not** check the Shrink or Expand boxes.



DOH 600-033 (6/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents: Physician Assistant (Medical) Application Packet

1. 656-135 .... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 656-129 .... Critical Information Sheet ..... 1 page
3. 656-115 .... Application Instructions For Certified Physician Assistants and Physician Assistants ..... 4 pages
4. 656-001 .... Application For Licensure To Practice As A Physician Assistant ..... 4 pages
5. RCW 18.130.170 Capacity of license holder to practice—Hearing—Mental or physical examination—Implied consent ..... 2 pages
6. RCW 18-130-180 Unprofessional conduct ..... 2 pages
7. 656-130 .... Physician Assistant Interim Permit Request Form ..... 1 page
8. 656-128 .... Washington State Medical Quality Assurance Commission Applicant's Professional Liability Action History ..... 1 page
9. 656-116 .... Request For Physician Assistant Program Transcripts ..... 1 page
10. 656-114 .... Verification/Evaluation of Training ..... 1 page
11. 656-112 .... Verification/Evaluation of Post Graduate Training ..... 1 page
12. 656-113 .... Verification of Licensing, Registration, or Certification as a Physician Assistant ..... 1 page
13. 656-111 .... Verification and Evaluation of Privileges ..... 1 page
14. 656-011 .... Mandatory Continuing Medical Education Information For Physician Assistants ..... 2 pages

These are the standard forms you should find within this application packet. Any of the verification forms can be copied as needed. There may be verification forms that are not needed or there may be additional requirements for which there are no forms; please read the instructions carefully in order to understand all that is required in order to be issued a license.

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Physician Assistant

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 656-135 (REV 6/2006)

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Washington State Department of Health

Critical Information

Effective July 1, 1999, the laws for physician assistants in Washington were changed to require certification through the National Commission on Certification of Physician Assistants (NCCPA) prior to being granted a license. This change did allow for an interim permit to be issued while waiting to take the examination, **HOWEVER that permit can only be issued for one year.** If you have not become certified within that year, you cannot reapply until you have passed the examination.

Physician Assistant Application/Renewal Fees:

Initial PA Application	$ 85.00
Reissuance PA Application	$150.00

WAC 246-918-990 Fees and renewal cycle. Licenses must be renewed every two years on the practitioner's birthday.

WAC 246-12-020(3) How to obtain a credential. The initial credential will expire on the practitioner's birthday, except for faculty or postgraduate education credentials authorized by law. Initial credentials issued within ninety days of the practitioner's birthday do not expire until the practitioner's next birthday.

WAC 246-12-310 Address changes. It is the responsibility of each practitioner to maintain his or her current address on file with the department. Requests for address changes may be made either by telephone or in writing. The mailing address on file with the department will be used for mailing of all official matters to the practitioner.

Important Telephone Numbers:

Applicants whose last names are between A—L.. (360) 236-4785...betty.elliott@doh.wa.gov

Applicants whose last names are between M—Z (360) 236-4784...helen.bogar@doh.wa.gov

It is very important that you allow enough time for your application to be processed. If you have scheduled a start date for employment, please be aware we may not be able to be held to this same time frame. Most of the time for processing is dependent upon the various entities and their priority in handling the requests for verification. Some entities require up to 8 weeks to process a request. We will try to accommodate due dates, however in some cases this will not be possible.

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Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Application Instructions for Certified Physician Assistants and Physician Assistants

Important Information—All Applicants

Prior to applying for licensure, please read through carefully and consider all the following laws related to applications:

____**RCW 18.130.180(2) Unprofessional Conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter: (2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

WAC 246-12-340 Refund of Fees. Fees submitted with applications for initial credentialing, examinations, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable.

____**WAC 246-918-007 Application Withdrawals.** An application for a license or interim permit may not be withdrawn if grounds exist for denial exist.

Guideline for physician supervisors: No physician who is designated as a sponsoring, supervising or alternate physician for any physician assistant shall allow that physician assistant to practice in any area of medicine or surgery that is beyond said physician's own usual scope of expertise and practice.

Qualifications for New Applicants

Effective July 1, 1999, applicants for a physician assistant license must have completed an accredited physician assistant program **AND** have taken and passed an examination approved by the commission. The examination approved by the Commission is administered by the National Commission on Certification of Physician Assistants (NCCPA).

Note: If you have not yet obtained certification by successful completion of the NCCPA examination, you can request an interim permit (form enclosed) that, along with an approved practice plan, will allow you to practice. Once issued, this permit will be valid for only one year so please consider that the exam is given a limited number of times per year. Consider allowing enough time for multiple chances to pass the examination.

Approval Process

After the application and appropriate fees have been received by the department, the applicant will periodically be notified of any deficiencies which may exist. Applicants should allow at least 6-8 weeks for documents to reach the department and be placed

with the application once they have been requested. Applications will not be considered complete until all required supporting documents are in the department. Only complete applications will be referred for review, which may require up to five (5) business days before processing a routine application for final approval and an additional 30 days for a non-routine application. All information, documents, data, etc., provided to the department by the applicant is to be submitted in writing and will become part of the file. Telephone information will not be accepted in place of written documentation.

Previous License in Washington

If you have ever held a license to practice medicine in the state of Washington, contact the office at one of the telephone numbers at the end of these instructions. The reinstatement of a license in this state is an entirely different process and requires different forms.

Application Information

It is the responsibility of the applicant to submit the correct forms to the appropriate entities for the purpose of obtaining verification information in support of the application for a physician assistant license. Documents submitted in support of the application must be submitted directly from the originating source. **Copies of transcripts, post graduate certificates, licenses, hospital privileges, examination scores, etc., will not be accepted.**

Applications pending after one (1) year will become invalid, along with the fee and any other supporting documentation. Should the applicant wish to pursue licensure after that time, it will be necessary to begin the process over with a new application, current fee, and all the supporting documents.

1. **Fee**—Original application $85.00 All fees are non-refundable. Please make checks payable to the Department of Health.
2. **Completed application**—All post graduate programs, experiences, and names and addresses of hospitals where privileges have been granted within the past five (5) years must be listed on the Professional Training and Experience section.
    A. **Photograph**—Current photograph, no larger than 2” by 2”, front view, taken within one (1) year. Do not submit instant Polaroid photographs other than passport photos. The photograph must be signed and dated across the bottom.
    B. **Personal Data Section**—Any positive answers to this section must be accompanied by an appropriate explanation and required documentation.
    C. **Malpractice**—Malpractice information must include the nature of the case, date and summary of care given. The applicant must complete the Professional Liability Action History form. The applicant must also include copies of the settlement or final disposition. If pending, indicate status.

D. **Education and Experience**—You must indicate complete chronology from the receipt of the physician assistant degree to the time of application. This must include month and year, and beginning and ending dates, whether part of medical practice or not. All time breaks of 30 days or more must be accounted for.

E. **Professional Training and Experience**—All applicable sections must be completed. If additional space is needed, you may then attach additional sheets. No C.V. or resume will be accepted in lieu of completing appropriate sections of the application.

F. **AIDS Education and Training Attestation**—AIDS affidavit must be initialed. AIDS training may include self study, direct patient care, courses, or formal training.

3. **Transcripts**—Applicants must have ***official transcripts*** sent directly from the Physician Assistant Program listing dates of attendance, subjects completed, degree and date awarded, if applicable. (Form provided.)
4. **Program Verification**—Verification of participation in an approved physician assistant program must be received directly from the program director's office. (Form provided)
5. **Licenses, Registration and Certification**—Verification of previous and current state certifications, registrations and licenses in ***any*** Health Care Profession must be sent directly to this office from the appropriate state regulatory authority. (Form provided)
6. **Hospital Privilege Verification**—Applicants must have verification sent directly to this office from ***all*** hospitals where admitting or specialty privileges have been granted in the ***past five (5)*** years. (Form provided)
7. **NCCPA Certification**—Applicants must request that their official results of the examination given by the National Commission on Certification of Physician Assistants (NCCPA) be sent directly to this office. (Form provided)
8. **Federation of State Medical Boards Data Bank Clearance Report**—This report will be obtained by Department staff, however, if staff is unable to obtain this report electronically, the applicant will be required to submit the request.
9. **Practice Plan**—The practice plan should represent the practice agreement between the physician assistant and the supervising or sponsoring physician. If other procedures are requested, attach a summary of training, demonstrating competence relating to those procedures.
10. **Prescriptive Authority**—Prescriptive Authority approved by the Commission is ***not*** DEA licensure. Please contact DEA directly at (206) 553-5996.

    A. Once the application is approved, a certified physician assistant is granted prescriptive authority for Schedules II-V Controlled Substances.

    B. Physician assistants may not prescribe Schedules II-V Controlled Substances unless so approved by the commission. ***Request for such approvals must be submitted on the official Prescriptive Authority Request Form.***

Continuing Medical Education—A licensee is required to have and attest to 100 hours of continuing medical education every two years for renewal of a license. Current certification with the National Commission for the Certification of Physician Assistants will be accepted in lieu of the 100 hour requirement.

Locum Tenens—Physician assistants who wish to serve a locum tenens position may do so by submitting a standard practice plan. Requests must meet standard practice criteria, to include but not limited to, remote site settings.

Termination of Sponsorship or Supervision—The certified physician assistant/physician assistant ***and*** sponsoring/supervising physician must submit a letter to the Commission indicating the reasons for termination of the relationship. (WAC 246-918-110)

Remote Site—A remote site is defined as a setting physically separate from the sponsoring/supervising physician's primary place of meeting patients or a setting where the physician is present less than 25% of the practice time of the physician assistant. Each request for utilizing a physician assistant in a remote site setting will be considered on a case-by-case basis. Physician assistants holding an interim permit will not be allowed to serve in a remote site setting. (WAC 246-918-120)

Applications and fees are to be sent to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be directed to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)
(360) 236-4700 (Customer Service Center—Renewals)

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

FOR OFFICE USE ONLY
ISSUANCE DATE
LICENSE #

LICENSE #

Application For License To Practice As A Physician Assistant

Check one (1) box only: ☐ Certified Physician Assistant ☐ Physician Assistant

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	— —

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male		

Have you previously applied for a Washington State license? ☐ Yes ☐ No

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

HEIGHT	WEIGHT
EYE COLOR	HAIR COLOR

MEDICAL SCHOOL	YEAR OF GRADUATION
NCCPA CERTIFICATION NUMBER	DATE ISSUED

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

2. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

2. Personal Data Questions (Continued)

	YES	NO
10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☐
11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☐
12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☐
13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☐

3. Education And Experience

Provide a chronological listing of your educational preparation and post-graduate training.
(Attach additional 8 1/2 X 11 sheets if necessary.)

SCHOOLS ATTENDED	NUMBER OF YEARS ATTENDED	Dates Attended		DIPLOMA OR DEGREE OBTAINED
		FROM (MO/YR)	TO (MO/YR)	
PHYSICIAN ASSISTANT EDUCATION (LIST ALL SCHOOLS ATTENDED)				
POST-GRADUATE TRAINING (IF APPLICABLE)				

4. Professional Experience

In chronological order list all professional experience received since graduation from Physician Assistant Program to the present. (Exclude activities listed under other sections, identify any periods of time break of 30 days or more.)
(Attach additional 8 1/2 X 11 sheets if necessary.)

NATURE OF EXPERIENCE OR PRACTICE	DATES OF EXPERIENCE	
	FROM (MO/YR)	TO (MO/YR)

5. Hospital Privileges

List hospitals where hospital privileges have been granted within the past five (5) years.
(Attach additional 8 1/2 X 11 sheets if necessary.)

NAME OF HOSPITAL	DATES	
	BEGINNING (MO/YR)	ENDING (MO/YR)

6. Licenses, Registration or Certification In Other States

List all licenses/registrations to practice in any health care profession obtained in other states. (Include whether active or inactive.)

STATE	DATE LICENSE ISSUED	PROFESSION	STATUS OF LICENSE		ANY LIMITATIONS ON LICENSE
			ACTIVE	INACTIVE	
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes

7. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

8. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____
SIGNATURE OF APPLICANT

_____
DATE

Official Use Only

Washington State Records Center

RCW 18.130.170 Capacity of license holder to practice—Hearing—Mental or physical examination—Implied consent. (1) If the disciplining authority believes a license holder or applicant may be unable to practice with reasonable skill and safety to consumers by reason of any mental or physical condition, a statement of charges in the name of the disciplining authority shall be served on the license holder or applicant and notice shall also be issued providing an opportunity for a hearing. The hearing shall be limited to the sole issue of the capacity of the license holder or applicant to practice with reasonable skill and safety. If the disciplining authority determines that the license holder or applicant is unable to practice with reasonable skill and safety for one of the reasons stated in this subsection, the disciplining authority shall impose such sanctions under RCW 18.130.160 as is deemed necessary to protect the public.

(2)(a) In investigating or adjudicating a complaint or report that a license holder or applicant may be unable to practice with reasonable skill or safety by reason of any mental or physical condition, the disciplining authority may require a license holder or applicant to submit to a mental or physical examination by one or more licensed or certified health professionals designated by the disciplining authority. The license holder or applicant shall be provided written notice of the disciplining authority's intent to order a mental or physical examination, which notice shall include: (i) A statement of the specific conduct, event, or circumstances justifying an examination; (ii) a summary of the evidence supporting the disciplining authority's concern that the license holder or applicant may be unable to practice with reasonable skill and safety by reason of a mental or physical condition, and the grounds for believing such evidence to be credible and reliable; (iii) a statement of the nature, purpose, scope, and content of the intended examination; (iv) a statement that the license holder or applicant has the right to respond in writing within twenty days to challenge the disciplining authority's grounds for ordering an examination or to challenge the manner or form of the examination; and (v) a statement that if the license holder or applicant timely responds to the notice of intent, then the license holder or applicant will not be required to submit to the examination while the response is under consideration.

(b) Upon submission of a timely response to the notice of intent to order a mental or physical examination, the license holder or applicant shall have an opportunity to respond to or refute such an order by submission of evidence or written argument or both. The evidence and written argument supporting and opposing the mental or physical examination shall be reviewed by either a panel of the disciplining authority members who have not been involved with the allegations against the license holder or applicant or a neutral decision maker approved by the disciplining authority. The reviewing panel of the disciplining authority or the approved neutral decision maker may, in its discretion, ask for oral argument from the parties. The reviewing panel of the disciplining authority or the approved neutral decision maker shall prepare a written decision as to whether: There is reasonable cause to believe that the license holder or applicant may be unable to practice with reasonable skill and safety by reason of a mental or physical condition, or the manner or form of the mental or physical examination is appropriate, or both.

(c) Upon receipt by the disciplining authority of the written decision, or upon the failure of the license holder or applicant to timely respond to the notice of intent, the disciplining authority may issue an order requiring the license holder or applicant to undergo a mental or physical examination. All such mental or physical examinations shall be narrowly tailored to address only the alleged mental or physical condition and the ability of the license holder or applicant to practice with reasonable skill and safety.

An order of the disciplining authority requiring the license holder or applicant to undergo a mental or physical examination is not a final order for purposes of appeal. The cost of the examinations ordered by the disciplining authority shall be paid out of the health professions account. In addition to any examinations ordered by the disciplining authority, the licensee may submit physical or mental examination reports from licensed or certified health professionals of the license holder's or applicant's choosing and expense.

(d) If the disciplining authority finds that a license holder or applicant has failed to submit to a properly ordered mental or physical examination, then the disciplining authority may order appropriate action or discipline under RCW 18.130.180(9), unless the failure was due to circumstances beyond the person's control. However, no such action or discipline may be imposed unless the license holder or applicant has had the notice and opportunity to challenge the disciplining authority's grounds for ordering the examination, to challenge the manner and form, to assert any other defenses, and to have such challenges or defenses considered by either a panel of the disciplining authority members who have not been involved with the allegations against the license holder or applicant or a neutral decision maker approved by the disciplining authority, as previously set forth in this section. Further, the action or discipline ordered by the disciplining authority shall not be more severe than a suspension of the license, certification, registration or application until such time as the license holder or applicant complies with the properly ordered mental or physical examination.

(e) Nothing in this section shall restrict the power of a disciplining authority to act in an emergency under RCW 34.05.422(4), 34.05.479, and 18.130.050(7).

(f) A determination by a court of competent jurisdiction that a license holder or applicant is mentally incompetent or mentally ill is presumptive evidence of the license holder's or applicant's inability to practice with reasonable skill and safety. An individual affected under this section shall at reasonable intervals be afforded an opportunity, at his or her expense, to demonstrate that the individual can resume competent practice with reasonable skill and safety to the consumer.

(3) For the purpose of subsection (2) of this section, an applicant or license holder governed by this chapter, by making application, practicing, or filing a license renewal, is deemed to have given consent to submit to a mental, physical, or psychological examination when directed in writing by the disciplining authority and further to have waived all objections to the admissibility or use of the examining health professional's testimony or examination reports by the disciplining authority on the ground that the testimony or reports constitute privileged communications.

[1995 c 336 8; 1987 c 150 6; 1986 c 259 9; 1984 c 279 17.]

NOTES:

Severability—1987 c 150: See RCW 18.122.901.
Severability—1986 c 259: See note following RCW 18.130.010.

RCW 18.130.180 Unprofessional conduct. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers or documents;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

[1995 c 336 9; 1993 c 367 22. Prior: 1991 c 332 34; 1991 c 215 3; 1989 c 270 33; 1986 c 259 10; 1984 c 279 18.]

NOTES:

Application to scope of practice—Captions not law—1991 c 332: See notes following RCW 18.130.010.
Severability—1986 c 259: See note following RCW 18.130.010.

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Physician Assistant Interim Request Form

I hereby request a **ONE TIME ONLY Physician Assistant Interim Permit**. I understand that the interim permit will expire one (1) year from the date of issuance. If, during that year the Commission receives verification from the NCCPA that I have passed the examination, this permit will be converted to a full PA-C license.

SIGNATURE DATE

PRINT OR TYPE FULL NAME AND DATE OF BIRTH

MAILING ADDRESS

An Interim Permit will be issued upon receipt of the following:

1. Completed Application Form;
2. Interim Permit Request Form;
3. Application Fee ($85.00);
4. Physician Assistant Program Transcript;
5. Physician Assistant Program Director Evaluation Form;
6. Verification from states that the applicant was or is licensed (if applicable);
7. Verification of hospital privileges granted in the last five (5) years (if applicable); and
8. A clear Federation of State Medical Boards (FSMB) data bank clearance report.

STOP!!! THE CLOCK WILL BE TICKING!!!

Before you send in this request form, please note that issuance of an Interim Permit is only part of what you need in order to practice as a physician assistant. The Commission must also approve a Practice Plan which outlines the working relationship between yourself and your physician preceptor. Only after the Practice Plan has been approved will you be able to begin practicing. Keep this in mind when considering when to send in this request form. Once your application is complete and you submit this request form, an Interim Permit ***will be issued*** and will be good for only ONE YEAR over issuance. You should also consider this: The required licensing examination (given by the National Commission on Certification of Physician Assistants—NCCPA) is given only two (2) times per year—in April and October. You may want to consider allowing enough time when requesting the Interim Permit for ***both*** chances to pass the examination. If you have any questions, please contact us at one of the numbers listed above.

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

PA

Washington State Medical Quality Assurance Commission

Applicant's Professional Liability Action History

Applicant's Name: _____ Today's Date: _____

Please submit a ***separate form for each past or current professional liability claim or lawsuit*** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

Date of occurrence: _____ Details: _____

2) Date suit or claim was filed: _____

Name and address of Insurance Carrier that handled the claim: _____

3) Your status in the legal action (primary defendant, co-defendant, other): _____

4) Current status of suit or other action: _____

5) Date of settlement, judgment, or dismissal: _____

6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount.

(You must enclose a copy of final disposition of case—this includes dismissals.) $ _____

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature: _____ Date: _____

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Request For Physician Assistant Program Transcripts

_____
UNIVERSITY

_____
ADDRESS

_____

_____

I am applying for licensure to practice as a physician assistant in the state of Washington. Please send a copy of my transcripts directly to the Washington State Medical Quality Assurance Commission at the address below. Thank you for your assistance.

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Applicant: Please complete the identifying information below to assist the registrar's office in processing your request.

Student Name: _____

SSN: _____

Year of Graduation: _____

Birthdate (MO/DAY/YR): _____

Contact Address: _____

_____

Contact Phone Number: _____

(This page intentionally left blank)

Washington State Department of Health

PA

TO: Physician Assistant Training Program Director

_____
MEDICAL INSTITUTION NAME

_____
ADDRESS

_____

RE: Verification/Evaluation of Training

I am applying for a license to practice as a physician assistant in the State of Washington and before my application can be reviewed, a verification and evaluation of the training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information below and returning it, at your earliest convenience, directly to the address shown below. All questions must be answered.

_____ _____
APPLICANT (PRINT OR TYPE) BIRTHDATE (MO/DAY/YR)

_____
SIGNATURE OF APPLICANT

1. _____ was engaged in our physician assistant program from _____ to _____.
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. At the time this individual completed the physician assistant program, was the program accredited through the Committee on Allied Health Education and Accreditation (CAHEA), the Commission on Accreditation of Allied Health Education Programs CAAHEP), or the Accreditation Review Committee on Education for the Physician Assistant (ARC-PA)? ☐ Yes ☐ No If yes, when was the initial accreditation granted?

_____
YEAR

3. **Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his or her participation in the program?** ☐ Yes ☐ No

If yes, please explain _____

_____

Return to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

(Seal)

Signature _____

Print Name _____

Title _____

P.A. Program _____
PLEASE TYPE OR PRINT

Address _____

_____

Date _____

Telephone _____

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Washington State Department of Health

PA

TO: Physician Assistant—Post Graduate Training Program Director

_____
MEDICAL INSTITUTION NAME

_____
ADDRESS

_____

RE: Verification/Evaluation of Post Graduate Training

I am applying for a license to practice as a physician assistant in the State of Washington and before my application can be reviewed, a verification and evaluation of the post graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information below and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

_____ _____
APPLICANT (PRINT OR TYPE) BIRTHDATE (MO/DAY/YR)

_____
SIGNATURE OF APPLICANT

1. _____ **is or was engaged in our post graduate training in our program from** _____ **to** _____ **,**
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

in the field of _____ **.**

2. Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ **Yes** ☐ **No**

If yes, please explain _____

_____

Return to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(Seal)

Signature _____

Print Name _____

Title _____

Medical Institution _____
PLEASE TYPE OR PRINT

Address _____

_____

Date _____

Telephone _____

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Washington State Department of Health

PA

TO: State Medical Licensing, Registration, or Certification

_____
MEDICAL INSTITUTION NAME

_____
ADDRESS

_____

RE: Verification of Licensing, Registration or Certification as a Physician Assistant or other health care profession

I am applying for a license to practice as a physician assistant in the State of Washington and before my application can be reviewed, a verification of my license status in your state is required. I am authorizing the release of and would appreciate you providing the information below and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

_____ _____
APPLICANT (PRINT OR TYPE) BIRTHDATE (MO/DAY/YR)

_____
SIGNATURE OF APPLICANT

This is to verify that _____ was issued license _____

number _____ on _____ as a _____ .
DATE TYPE OF LICENSE

1. **Date license, registration, or certification issued** _____ **Date of expiration** _____ .
2. **Have any complaints been lodged against the license?** ☐ **Yes** ☐ **No**
3. **Is there currently any investigation in process regarding the license?** ☐ **Yes** ☐ **No**
4. **Has any disciplinary activity taken place regarding this license?** ☐ **Yes** ☐ **No**

If yes, please provide any information and documentation which may be released; i.e., charges and final disposition.

Return to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(Seal)

Signature _____

Print Name _____

Title _____

Medical Institution _____
PLEASE TYPE OR PRINT

Address _____

_____

Date _____

Telephone _____

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Washington State Department of Health

PA

TO: Hospital Administration

_____
MEDICAL INSTITUTION NAME

_____
ADDRESS

_____

RE: Verification and Evaluation of Privileges

I am applying for a license to practice as a physician assistant in the State of Washington and before my application can be reviewed, a verification of my employment with evaluations, is required. I am therefore authorizing the release of and would appreciate you providing the appropriate information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

_____ _____
APPLICANT (PRINT OR TYPE) BIRTHDATE (MO/DAY/YR)

_____
SIGNATURE OF APPLICANT

1. _____ **now has/has had admitting or specialty privileges**

at this hospital from _____ **to** _____ **.**
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

☐ **Yes** ☐ **No** **if yes, please explain** _____

_____

3. Has the applicant ever been asked to resign? ☐ **Yes** ☐ **No** **if yes, please explain** _____

_____

Return to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(Seal)

Signature _____

Print Name _____

Title _____

Medical Institution _____
PLEASE TYPE OR PRINT

Address _____

_____

Date _____

Telephone _____

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Washington State Department of Health

Mandatory Continuing Medical Education Information For Physician Assistants

WAC 246-12-170 When is continuing education required? Continuing education is required for renewal of a credential only if authorized in law. The regulatory entity defines the continuing education requirements. Practitioners should refer to the laws and rules relating to their profession to determine if continuing education is required.

General Requirements:

The Washington State Medical Quality Assurance Commission requires all currently registered physician assistants to show one hundred (100) hours of Continuing Medical Education (CME) every two years along with their license renewal which falls on their birthdate. Failure to report CME renders the renewal invalid and to continue to practice constitutes a gross misdemeanor.

WAC 246-918-180(2) In lieu of 100 hours of CME, the Commission will accept current certification with the National Commission for Certification of Physician Assistants (NCCPA) and will consider approval of other programs as they are developed.

WAC 246-918-180(4) The Commission approves the following categories of creditable continuing medical education. A minimum of forty credit hours must be earned on Category I.

WAC 246-918-180(7) It will not be necessary to inquire into the prior approval of any continuing medical education. The Commission will accept any continuing medical education that reasonably falls within these regulations and relies upon each licensee's integrity in complying with this requirement.

WAC 246-918-180(8) Continuing medical education sponsors need not apply for nor expect to receive prior commission approval for a formal continuing medical education program. The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of the program sponsors to present continuing medical education for licensees that constitutes a meritorious learning experience.

WAC 246-12-180 How to prove compliance. If continuing education is required for renewal, the practitioner must verify compliance by submitting a signed declaration of compliance.

WAC 246-12-210 When is a practitioner exempt from continuing education? A practitioner may be excused from or granted an extension of continuing education requirements due to illness or other extenuating circumstances. The profession's regulatory entity determines when the requirements may be waived or may grant an extension.

WAC 246-12-220 How credit hours for continuing education courses are determined. A credit hour is defined as time actually spent in a course or other activities as determined by the regulatory entity as fulfilling continuing education requirements. A credit hour for time actually spent in a course cannot be less than fifty minutes.

WAC 246-12-230 Carrying over of continuing education credits. Continuing education hours in excess of the required hours earned in a reporting period cannot be carried forward to the next reporting cycle.

WAC 246-12-240 Taking the same course more than once during a reporting cycle. The same course taken more than once during the reporting cycle will only be counted once.

All fees should be directed to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries or documents should be directed to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)
(360) 236-4700 (Customer Service Center—Renewals)